

Centers for Medicare & Medicaid Services, HHS

§ 422.2

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 63 FR 18134, Apr. 14, 1998, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

Subpart A—General Provisions

SOURCE: 63 FR 35068, June 26, 1998, unless otherwise noted.

§ 422.1 Basis and scope.

(a) *Basis*. This part is based on the indicated provisions of the following sections of the Act:

- 1851—Eligibility, election, and enrollment.
- 1852—Benefits and beneficiary protections.
- 1853—Payments to Medicare Advantage (MA) organizations.
- 1854—Premiums.
- 1855—Organization, licensure, and solvency of MA organizations.
- 1856—Standards.

- 1857—Contract requirements.
- 1858—Special rules for MA Regional Plans.
- 1859—Definitions; enrollment restriction for certain MA plans.

(b) *Scope*. This part establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans.

[63 FR 35068, June 26, 1998, as amended at 70 FR 4714, Jan. 28, 2005]

§ 422.2 Definitions.

As used in this part—

Arrangement means a written agreement between an MA organization and a provider or provider network, under which—

- (1) The provider or provider network agrees to furnish for a specific MA plan(s) specified services to the organization's MA enrollees;
- (2) The organization retains responsibilities for the services; and
- (3) Medicare payment to the organization discharges the enrollee's obligation to pay for the services.

Balance billing generally refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost-sharing by the individual.

Basic benefits means all Medicare-covered benefits (except hospice services).

Benefits means health care services that are intended to maintain or improve the health status of enrollees, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process.

Coinsurance is a fixed percentage of the total amount paid for a health care service that can be charged to an MA enrollee on a per-service basis.

Copayment is a fixed amount that can be charged to an MA plan enrollee on a per-service basis.

Cost-sharing includes deductibles, coinsurance, and copayments.